SCOTTISH DRUG DEATHS TASKFORCE

Medication Assisted Treatment (MAT) Standards for Scotland

Access, Choice, Support

Consultation on the standards & implementation

The term Medication Assisted Treatment (MAT) is used in this document to refer to the use of medication, such as opioids, together with any psychological and social support, in the treatment and care of individuals who experience problems with their drug use.

Foreword from people with lived and living experience of substance use

The road to reducing drug related deaths is rocky and twisting but is one we must persevere on if we are to go any way towards making Scotland a safe and happy place to live for everybody. All lives are precious, all children should expect to be nurtured and feel safe. All parents should expect their children to live long productive lives. As members of this Taskforce with lived experience we have a responsibility to ensure that every avenue is explored, that the range of options is wide and daring and that there is an option at the right time, in the right circumstances for the right person.

We have all seen drug deaths continue to rise within our communities. We believe it is vital we adapt and evolve our current systems using compassion, kindness, respect and dignity. For families, with years of experience of supporting their loved ones, removing barriers and ensuring equality of access, choice and support across all treatment and care in all areas of Scotland is essential.

By using our collective past experiences of what we know isn't working we can become thought leaders and identify new methods and systems in order to better, not only support people with drug and alcohol issues and their families, but also work with communities to become more open and inclusive to supporting vulnerable people experiencing these issues.

Our priority is to place vulnerable people at the centre of our services and the importance of treating individuals with dignity and respect, being non-judgemental in all of our approaches, and the majority of the time we are successful. However, we must continue to encourage and motivate people when they are ready to access the help and support they need.

It is vital to move towards a national approach, to ensure a consistent service will be offered and available to access around Scotland. These standards have a significant part to play in helping vulnerable people affected by substance use. It is worth considering, if you or a loved one had to engage with any service in desperate need of help and support, how would you wish, indeed expect, yourself or that person to be treated?

Optimising the use of Medication Assisted Treatment (MAT) will ensure that people have immediate access to the treatment they need with a range of options and the right to make informed choices. If an individual chooses this option within a robust Recovery Oriented System of Care (ROSC) they should expect to receive good quality, person centred care, immediately (if required) with supports into other services and opportunities for challenge and growth.

We support the implementation of the MAT Standards across our nation as an integral part in challenging all services to provide access to good quality care no matter where you are in the country and will provide a vital role within the six evidence based strategies set out by the SDDTF.

Becky Wood
Allan Houston
Colin Hutcheon

November 2020

Foreword from the Chief Medical, Pharmaceutical and Nursing Officers of Scotland

We have to be bold in our efforts to reduce drug harm and drug deaths. In order to support individuals, families and communities one of the greatest opportunities we have is ensuring people receive high quality treatment and care.

The Scottish Drug Death Taskforce (SDDTF) set out 6 evidence-based strategies for preventing drug-related deaths in Scotland, including optimising the use of Medication-Assisted Treatment (MAT), which consists of pharmacological, psychological and social support for people who experience problems with their drug use. This approach is recognised and approved by medical authorities, and forms part of Scotland's eight-point treatment plan to improve recovery-oriented systems of care.

Whilst this is not the only strategy set by the Taskforce it is important to recognise that MAT is one of the most effective interventions to support people with opioid dependence. With opiates and opioids implicated in the vast majority of drug-related deaths (86%), high quality MAT represents a lifesaving intervention for those in greatest need.

The MAT Subgroup of the SDDTF have developed standards around this, with the aim to define national expectations for the consistent delivery of 'no barrier' medication assisted treatment in Scotland. The standards apply to all recovery-oriented systems of care.

The development of these standards will help outline fair expectations for all to ensure that individuals receive high quality care and support when taking this route in their recovery journey.

We welcome the development of these standards and we would encourage those with a particular interest, including those working in harm reduction, prescribing and outreach, but also those currently in treatment services, as well peers or others with lived experience, to take part in the consultation on their implementation. This will ensure that the development of these MAT standards is an inclusive process and that, in delivery, they will meet the wider expectations of all those affected, individuals and their families.

Dr Gregor Smith – Chief Medical Officer November 2020

Fiona McQueen - Chief Nursing Officer

Alison Strath – Interim Chief Pharmaceutical Officer

Development of the standards

The Medication Assisted Treatment (MAT) subgroup of the Scottish Drug Death Taskforce (SDDTF) has oversight of the development and implementation of the MAT standards on behalf of the SDDTF. An expert advisory group developed the standards, and the MAT programme team is working with partners to consult on and support the implementation of the standards

Since November 2019, a series of strategic engagements and local visits have been undertaken to present the draft standards, ask for feedback, identify local practice that could be shared, and provide support for implementation. This work has continued throughout most of 2020 in spite of the disruption caused by the SRAS-CoV-2 pandemic; in fact across Scotland, service changes and innovations in response to the pandemic have presented many opportunities for development. In some ADP areas, quality improvement projects have been identified and programme support agreed. Some projects by the MAT programme team are now complete and some are consolidated as part of usual practice (Appendix 1 for list of contributors)

The standards document is presented as a work-in-progress. This is because:

- Standards 1-5 address mainly access and choice, and have been the focus for early development and implementation support.
- Standards 5-10 rely more on a complex system wide approach to care and support, so detail such as what needs to be in place to deliver the standard is less advanced.
- The focus of developments so far has been to address opioid dependence[i], but the standards aim to support system improvements for *all* drug related problems.

We are seeking feedback on the following:

- To what extent will each standard make a difference to reducing drug deaths in Scotland?
- How long it would take your service or local area to fully implement this standard?
- What are the implications for your service or local area to deliver this standard?

[i]In 2018, one or more opiates or opioids (including heroin/morphine and methadone) were implicated in, or potentially contributed to 86% of deaths (1,021 of the 1,187 recorded that year).

- What key requirements, in addition to those set out in this document, would you need to be in place to deliver the standard?
- Practical examples of local evidence to measure progress against a given standard.

From people with personal or family experience of problematic drug use, we would also like to know:

- Your experiences of treatment care and support against each of the standards.
- Whether you think the standards will make a difference to your experience of services.
- Anything else you would like to see included.

There will be a 10 week consultation on the standards to end January 2021. This will include a launch webinar with the Minister for Public Health, an online survey, a programme of online workshops and a continuation of the existing programme of direct engagement with local teams. The views of people and their families who have experience of problematic drug use are crucial to the successful implementation of the standards. Specific engagement work will include these groups.

The next phase of our work will focus on four main areas.

- Further engagement and quality improvement support.
- Further review of published literature and successful practice in Scotland and elsewhere.
- The development of an assessment framework to measure local and national progress against the standards
- Collaboration with Healthcare Improvement Scotland (HIS) to develop approved standards that can support sustainable service improvements.

The following resources are available online (please click to follow link)

i) The online survey consultation for your responses to the standards
ii) The calendar of consultation events
iii) The progress map for ADPs improvement work against the standards

SCOTTISH DRUG DEATHS TASKFORCE

Medication Assisted Treatment (MAT) Standards Access, Choice, Support

Introduction

Background to the standards

Scotland has a high level of drug-related deaths (DRD). The annual figure for 2018 increased from the previous year by 27% to 1,187, and this is the highest number recorded for the fifth year in a row. The Scottish Drug Deaths Taskforce (S DDTF) has prioritised the introduction of Medication Assisted Treatment (MAT) standards to help reduce deaths. The standards aim to ensure that MAT is sufficiently safe, effective, accessible and person centred to enable people to engage in treatment for as long as they need.

The Scottish Government's drug and alcohol treatment strategy Rights, Respect & Recovery[1] sets out a clear policy to deliver evidence based interventions through a public health approach. There is good evidence that the health of individuals with opioid dependence is safeguarded while in substitution treatment.[2] Evidence also indicates that it is important to consider medication choice and that optimum dose is critical to achieving positive outcomes. Evidence shows elevated mortality risks during the first 4 weeks of treatment and the first 4 weeks after leaving treatment. This demonstrates that these are critical intervention points to support people in substitution treatment and prevent drug-related deaths. A holistic approach, designed and tailored to the health and social needs of individuals, will improve the effectiveness of interventions, help increase motivation, prevent drop-out and improve the experience of people using services.[3]

The most recent analysis of the circumstances of people who had a drug-related death in Scotland uses data from 2015/2016, and this shows that over half (52%) of the individuals who died lived in the 20% most deprived neighbourhoods in Scotland.[4]These deaths are symptomatic of marginalisation and inequitable social conditions, and they highlight the need to prioritise people

most at risk and to offer intensive treatment and support to tackle this inequality.[5] In 2018 Information Services Scotland [6](now Public Health Scotland) estimated that in 2012/13, only 35% of those with people with problematic opioid or benzodiazepine use were in a structured treatment service.

To reduce harm and promote recovery, the Drugs Death Taskforce[7]has prioritized low barrier access to MAT. Implementation of the MAT standards is a rights-based approach[8] and follows the principles of the Scottish Government Health & Social Care Standards[9].The standards are in line with the vision for NHS Scotland that by 2025 anyone providing health and social care will take a realistic medicine approach[10], that puts people at the centre of decisions made about their care and how it is delivered.

The aim and scope of the standards

The MAT standards define what is needed for the consistent delivery of 'no barrier' MAT in Scotland. The standards apply to all services and organisations responsible for and involved in the delivery of recovery oriented systems of care for people who experience problems with their drug use, and their families.

The approach to implementation of the standards

To implement the standards, collaboration, shared learning and an appreciation of local circumstances is central to success. People involved in the commissioning, design, management and delivery of services need to work closely with people who have personal or family experience of problematic drug use. The MAT team will deliver a programme of quality improvement support to NHS Boards, Alcohol and Drug Partnerships (ADPs), third sector partners and community groups to help achieve this. Programme support will be through virtual meetings, site visits, workshops, networking and direct support with quality improvement (QI), reporting and dissemination.

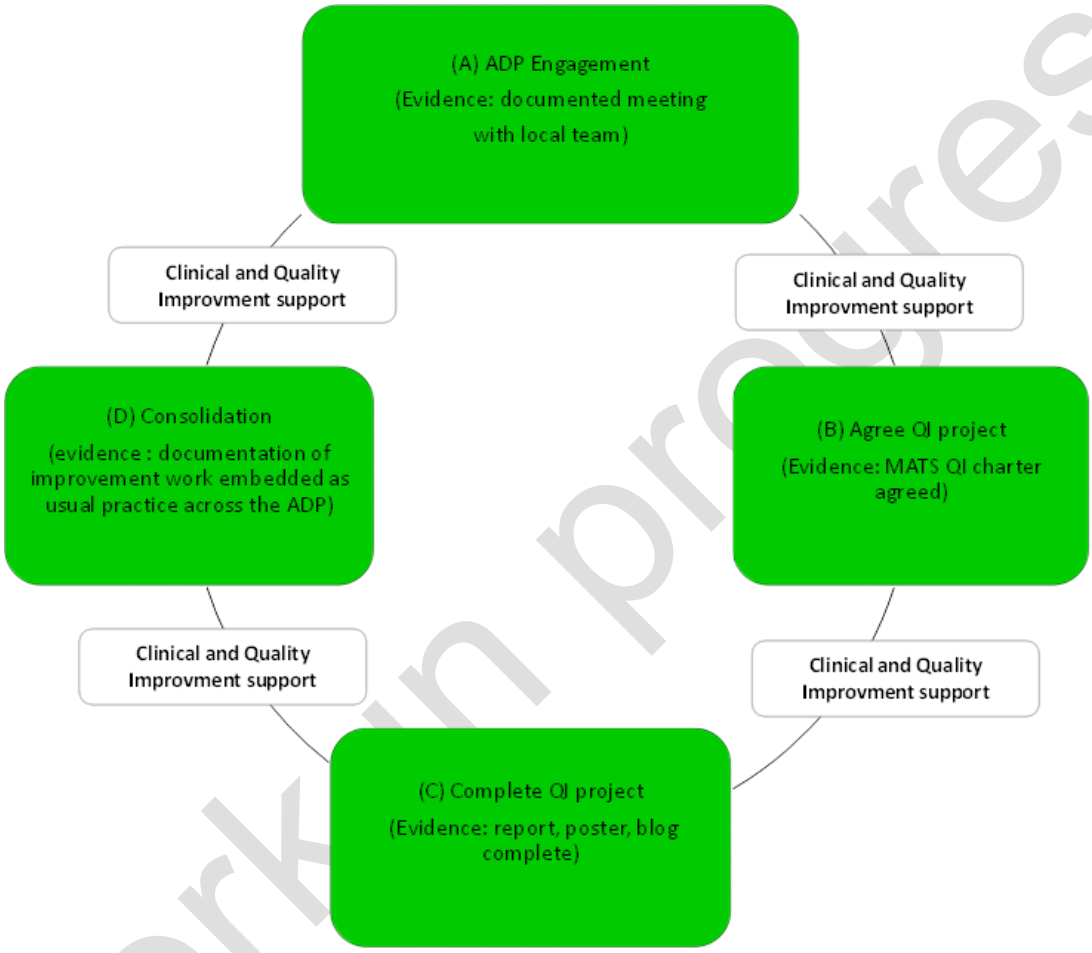
The principles for implementation of the standards

1. A clear purpose – MAT is to reduce harm, prevent death and support recovery among people who experience problems with their drug use.
2. No barriers - services should operate a policy of no barriers to access treatment.
3. Informed choice – people should be offered a range of entry points into treatment, a range of treatment options and be empowered to make informed choices that meet their needs at a given time.
4. A person centred therapeutic relationship – the elements and goals of a person's treatment should be agreed between themselves and their practitioner. Problematic drug use can be short or medium term for some people, but for many people this is a long term condition and should be managed as such.This means that the practitioner must understand that there is validity in all approaches. Approaches include the following.
    - Harm reduction where a person may choose to use illicit drugs with precautions such as new injecting equipment and safe injecting techniques, while also on MAT.
    - Abstinence from illicit drugs with the assistance of MAT and which can be long term, in line with treatment of other long term conditions.
    - Well planned supported detoxification with or without residential options
5. A trained workforce –local and national leaders should establish clear policies and expectations and ensure sufficient workforce capacity is available to meet them. Individual practitioners should have the attitudes, knowledge, skills and abilities to deliver the standards.

Implementation of the standards

1. Quality Improvement- we will meet with ADPs and other partners to discuss the standards, provide direct support for agreed QI work and facilitate dissemination of experiences across Scotland (Figure 1.). This work has been ongoing since November 2019 and progress against the four steps is shared and available online through the SDDT website (please click to view).

Figure 1. Engagement and Quality Improvement (QI) work



2. Measurement of success – we will establish a programme to assess local and national progress towards achievement of the standards. The assessment programme has three components.
   - Examples of evidence which can confirm the standard has been met will be collected as part of the consultation and included in the final standards document. These are intended for use by local partnerships to demonstrate progress against the standards. Over time these measures can also be used to assess and share progress across all areas in Scotland.
   - Quality improvement measures for change initiatives will be agreed with local teams.

- National measures will be developed and aligned to the Monitoring and Evaluation Framework of Rights Respect and Recovery.

Note: measurement of success will be evaluated through quantitative *and* qualitative methods which will include people delivering and experiencing MAT services.

3. Healthcare Improvement Scotland (HIS) Standards for drug services – we will collaborate with HIS to publish standards that bring together the MAT standards, the Quality Principles: standard expectations of care and support in drug and alcohol services[11], Staying Alive in Scotland and the Rights Respect & Recovery Action Plan.

Format of the standards

Each standard includes the following.

- The Standard - a statement of the required level of performance.
- The Rationale – an explanation of why the standard is important.
- The Key requirements–a list describing what needs to be in place to deliver the standard.

Summary of the standards

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence, re-commence or continue MAT.
4. All people are offered evidence based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
6. The system that provides MAT is psychologically and trauma informed (Tier 1); routinely delivers evidence based low intensity psychosocial interventions (Tier 2); and supports the development of social networks.
7. All people have the option of MAT shared with Primary Care.
8. All people have access to advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery
10. All people receive trauma informed care.

Terminology

Wherever possible, we have incorporated generic terminology which can be applied across all settings. The term 'person' or 'people' is used to refer to the person experiencing MAT care and support. Throughout this document, we have used the term provider to refer to the relevant organisation, team or practitioner that is offering components of MAT. On occasion, where necessary, we refer to specific providers such as GPs. The word 'service' refers to a particular team that is delivering MAT e.g. a city centre harm reduction team or a locality team within a Local Authority area.

STANDARD ONE

People have the option to start MAT from the same day of presentation

Rationale

- The Orange Guidelines[12]recommend that
  - services should avoid unnecessary steps in the assessment process, particularly to reduce the risk of harm for people who need to stabilise on opioid substitution therapy. It is possible to make a diagnosis of dependence and establish sufficient information for a prescribing decision to be made at the first appointment (2017; p37).
  - the information needed to start MAT should be obtained without adding delay as this places the person at risk of dropping out of treatment (2017; p94)
- Further evidence suggests that rapid access to MAT meets the needs of highly vulnerable groups, such as people experiencing homelessness, and that it reduces heroin use, HIV and hepatitis C virus (HCV) risk, injection related and all-cause mortality and criminal charges.[13]

Key requirements

- A written policy for 'no barrier' access to MAT that includes
  - a requirement for the availability, at the time of a person's presentation, of practitioners competent to confirm dependence through history, examination and point-of-care urine drug testing and to initiate same day medication.
  - updated governance procedures to guide practitioners.
  - clarity that MAT is not contingent on uptake of other interventions or on abstinence from other drugs.
  - a range of referral options including self-referral and drop-in services.

STANDARD TWO

All people make an informed choice on what medication to use for MAT and the most appropriate dose

Rationale

- The Orange Guidelines[14] recommend 60-120mg of methadone or 12-16mg of buprenorphine as optimal therapeutic doses. However, more recent research suggests that prescribing needs to take account of a person's perception of dose efficacy.
- Trujols and colleagues (2019) have identified that a person's perception of dose adequacy is influenced, not just by the pharmacological effects of MAT, but also by their satisfaction with the care they receive. In this study, especially important factors were respect for autonomy and choice, the skills, behaviours and attitudes of providers, and the impact of stigma[15].
- A validated scoring system such as the Opiate Adequacy Score (ODAS)[16] can help to incorporate perceptions of providers and people in MAT into dosing decisions.

Key requirements

- Methadone and long and short-acting buprenorphine formulations should be equally available in local formularies and dispensing locations.
- Prescribing guidelines should be available for each MAT option.
- People should be aware of options in medication and be able to move readily from one medication to another.
- Providers should ensure that appropriate information is provided to people in a format that empowers and enables informed decision making.
- All medication and dosing decisions should be made collaboratively and take into account a person's treatment goals.
- A schedule for review of the care plan should be agreed between the person and the provider.

STANDARD THREE

All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT

Rationale

- The following factors indicate a higher risk of drug related death[17]: injecting drug use, polydrug use, mental health difficulties, not being in treatment, recent experience of near-fatal overdose, unstable housing or homelessness, social isolation and recent hospital, prison or residential care discharge.
- Assertive outreach services should be available to identify and connect with people at high risk but not in MAT. The Orange Guidelines[10] identifies that people who are experiencing homelessness require a different clinical response, such as assertive outreach, to link with specialist teams.
- Combined peer outreach and treatment interventions that target out-of-treatment individuals, have been shown to support people into MAT[18], optimize care and prevent people dropping out.

Key requirements

- Established partnership agreements including data sharing agreements between the NHS boards, Health and Social Care Partnerships, third sector agencies, Police Scotland, the Scottish Ambulance Services (SAS), primary care, A&E, and so on.
- A systematic and documented procedure for identifying people at risk through for example, interactions with SAS, A&E, GPs, hospital discharge, housing or other sources. For example this may include receipt of lists from SAS, Police Scotland and routine admission reports from A&E.
- A procedure for the timely sharing of information about people experiencing a near fatal overdose, with partners who can take responsibility for follow up. For example this could be coordinated through a virtual hub on a daily or weekly basis,
- Every near-fatal overdose should
  - trigger an urgent assertive outreach approach, the same day if possible

  - be supported by a range of agencies to provide person centred care that includes rapid initiation onto MAT where appropriate.
- Care provided should be tailored to the needs of the individual and may include urgent medical review, provision of food, utility loans, housing, help for individuals to attend appointments and police welfare checks.
- An effective monitoring and evaluation system which provides timely feedback on performance to staff and the community at risk and that feeds into a continuous quality improvement process.

STANDARD FOUR

All people can access evidence based harm reduction at the point of MAT delivery

Rationale

- The Orange Guidelines[19] recommend that regular appointments during MAT should provide opportunistic interventions such as hepatitis and HIV testing, injecting equipment provision and overdose and naloxone training (p38).
- It is understood that some people in MAT may decide to continue to use illicit drugs e.g. crack cocaine or heroin. There are other benefits of MAT, such as opportunities to participate in psychosocial interventions, general medical care, hepatitis C and HIV treatment, access to benefits, housing and peer support, that accrue over time and which may be of greater importance to the person than the cessation of illicit drugs[20].
- The stigmatization of people who continue to use drugs, reducing their dose, not offering IEP or other punitive actions as a consequence of ongoing substance use actively discourages engagement and retention in treatment.

Key requirements

- Established cross service agreements on staff training, responsibilities, resource allocation, professional networks and expedited referral mechanisms.
- Services should ensure that injecting equipment is available at times and in all places that meet the needs of people who inject drugs
- Where possible sites providing injecting equipment should
  - offer a full range of injecting equipment that includes low dead space syringes and barrels
  - place no limits on the amount of injecting equipment people can access
  - provide advice relevant to the type of drug being injected, the anatomical point of injection and the location in which the drugs will be prepared and injected
  - conduct a basic assessment of injecting risk
  - identify, treat and refer injecting-related wounds and other complications
  - offer naloxone at every opportunity

  - offer hepatitis and HIV testing and hepatitis B vaccination
- A supply of naloxone should be available for emergency use across all services that work with people experiencing problematic drug use
- People are made aware of local and national issues such as outbreaks of bacterial wound infections or of HIV or hepatitis infections that will affect the delivery and ability to benefit from services.

STANDARD FIVE

All people receive support to remain in treatment for as long as requested

Rationale

- The Orange Guidelines[21]recommends
  - that appointment frequencies should reflect clinical need and efficient use of resources (p38). More socially stable service users who may not need frequent attendance can be over treated or over supervised and this can have a detrimental effect on their ability to return to sustain a stable lifestyle. Attendance requirements must not be arbitrary and should respect people personal circumstances (p38).
  - flexible arrangements for appointments, particularly for people who are homeless and with co-morbidities or social issues that affect their ability to engage or organise their time (p94). Offering people only fixed appointment times is an unjustifiable barrier to access, ties up practitioner capacity and is an unnecessary waste of resources.
  - segmentation and caseload management of psychosocial interventions (p52) avoiding a 'one-size fits all' which is ineffective and impractical. A flexible response offering different care packages ranging from low intensity for people not requiring or wanting more involvement, to intensive recovery focused packages for others.

Key requirements

- The service should have a detailed understanding of the caseload that can identify the following:
  - people with complex needs requiring intensive specialist input, e.g. ongoing high-risk polypharmacy, multi-morbidity or polysubstance use.
  - people needing 2-3 monthly MAT reviews who are also receiving support from other agencies.
  - people who would be more appropriately managed in primary care.
- Established shared care arrangements with primary care that includes proactive and supported transfer of people stable on MAT.

- An appropriate division of labour to improve the flow of people across multidisciplinary and cross sectoral teams. This means providers must work to the highest point of their professional capacity. For example, third sector organisations provide key-working, mental health nurses conduct MAT assessments, initiation and reviews.
- Shared clinical record keeping.
- A variety of strategies to manage caseloads and appointment systems e.g. including group or café style clinics, 'corporate' caseloads, a mix of drop in and fixed appointments, after hours provision, and pharmacy-based maintenance clinics.
- Monitoring and service improvement plans to reduce non-attendance at appointments.

STANDARD SIX

The system that provides MAT is psychologically and trauma informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports the development of social networks

Rationale

- The Lead Psychologists in Addiction Services Scotland (LPASS) Report[22] and the Orange Guidelines[23] provide compatible and complimentary frameworks for the effective delivery of both psychologically informed care and structured psychosocial interventions.
  - They clearly illustrate that for substance use services to be fully effective (including MAT), they must be psychologically and trauma informed in all they do.
  - They outline the extensive evidence-base for low intensity psychosocial interventions, and illustrate how such interventions can be woven into the fabric of MAT treatment delivery to improve engagement and efficacy
  - They highlight the importance of strong clinical governance when delivering psychosocial interventions, in particular ensuring that the workforce are appropriately trained, supported and supervised.
  - In short, as well as illustrating the key value of psychologically informed care and psychosocial interventions, these documents provide clear guidance to services on which psychosocial interventions should be delivered, when, by whom, and with what training and supervision.

Key requirements

- Commitment is required at commissioning and senior leadership level to ensure that this work is prioritised and appropriately resourced.
- Services should have explicit plans for delivering psychologically informed care including Tier 1 and Tier 2 psychological interventions. Plans should include the following:
  - staff training and coaching
  - supervision arrangements for staff

  - translation of training into practice
  - audit and service improvement work
  - supportive tools, protocols, manuals etc.
- Clear pathways should be established for timely referral into Tier 3 & 4 psychological interventions

STANDARD SEVEN

All people have the option of MAT shared with Primary Care

Rationale

- The Orange Guidelines[10]identify joint working across health and social care and between hospital, prison, primary care and community drug services as a key feature of effective treatment partnerships (p13).
- An ageing and increasingly co-morbid population with comparatively high rates of all cause mortality will benefit from MAT delivered in primary care, due to the possibility of wider health problems being met[24]
- MAT offered in primary care helps to address issues around access to drug treatment services in rural areas[25].

Key requirements

** workshops with primary care colleagues scheduled
as part of consultation to inform implementation – please see calendar of events**

STANDARD EIGHT

All people have access to advocacy and support for housing, welfare and income needs

Rationale

- Studies have consistently shown a high prevalence of co-morbidity of mental disorders in people experiencing problematic drug use and a clear association with homelessness and experience of the criminal justice system[26 27].
- The 'Housing First' model provides rapid housing that is not conditional on abstinence from drug use. A systematic review and meta-analysis[28] of randomised controlled trials of the housing first approach conducted in 2019 showed improved housing stability and health, reductions in homelessness and non-routine health service, and no increases in problematic drug use.
- The single biggest structural driver of problematic drug use is poverty and deprivation. Problematic drug use is more prevalent among people from more deprived areas and from less advantaged backgrounds[29]
- The current benefit system allows the payment of incapacity benefits dependent upon compulsory appointments, work searches and training with the threat of benefit sanctions for noncompliance. Among people with mental health conditions, including problematic drug use, is the system is associated with negative health outcomes that make future employment less likely[30].
- Benefits sanctions (e.g. stopping benefit payments for a minimum of four weeks) often leave people facing economic hardship and the need to use food banks[31].
- There is evidence from a systematic review that welfare rights advice delivered in healthcare settings results in financial benefits for those eligible[32]

Key requirements

- Established housing, welfare and advocacy support referral pathways for people using MAT services.
- A system to assess need and make the right referrals at the right time.

***developments ongoing with advocacy leads across the country, with workshops scheduled as part of consultation to inform implementation – please see calendar of event ***

STANDARD NINE

All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery

Rationale

- The Scottish Government recommends that service integration ensures alcohol, drugs, mental health and social services work jointly and in a holistic way, and that they try out improved service arrangements for dual diagnosis[33].
- In clinical practice, integrated dual diagnosis treatment is recommended, but there is limited research evidence of definite benefit[34].
- A 2013 study of onsite and integrated psychiatric service delivery found that integrating psychiatric and substance use services in opioid agonist treatment settings might improve psychiatric outcomes but not necessarily improved drug use outcomes[35].
- A 2019 study supported the benefits of integrated psychiatric and substance use care for people with opioid use disorder, with or without a co-occurring personality disorder[36].
- From the perspective of people experiencing MAT, a systematic review has identified that integrated dual diagnosis treatment has high levels of satisfaction[37].

Key requirements

** workshops with specialist colleagues scheduled
as part of consultation to inform implementation – please see calendar of events**

STANDARD TEN

All people receive trauma informed care

Rationale

- Trauma is everyone's business: we all have a part to play in understanding and responding to people recovering from trauma.
- The majority of people accessing MAT services have extensive histories of psychological trauma. The consequences of being exposed to trauma may be intrinsically linked to the individual's drug use.[38] Unaddressed trauma-related issues are a significant barrier to people accessing and benefitting from MAT services.
- Trauma informed care provides benefits for the people accessing the service and for their families, service providers and the wider community.
- The Orange Guidelines[39]includes trauma informed care as an essential element of MAT provision (p41-42) and best practice guidance is set out in *The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014)*, *Transforming Psychological Trauma: A Knowledge and Skills Framework (2017)*[40]and *The delivery of psychological interventions in substance misuse services in Scotland (2018)*[1]

Key requirements

- Trauma informed leadership is required to promote the core values and principles of trauma informed care.
- MAT services should have an explicit plan for delivering trauma informed care. This should include the following.
  - Inclusion of people with experience of psychological trauma in service delivery.
  - Review of policies that affect staff and individuals accessing MAT.
  - The use of validated tools[2] for routine trauma screening to support treatment planning and recovery.
  - Trauma training and implementation plans for the MAT workforce (including senior leaders) which are aligned to the core knowledge and skills required for each role.[4]
  - Review of staff recruitment processes e.g. job descriptions, interview process and feedback, staff induction when starting to work in MAT services.

- Processes to maximise staff wellbeing and reduce the risk of secondary traumatisation, burnout and compassion fatigue.
- Considerations for the physical environment within which MAT is delivered.
- The provision of evidence based psychological interventions and approaches within MAT services.[1]
- Supervision arrangements for the workforce delivering psychological interventions for trauma
- A plan for monitoring, evaluating and adapting changes to policy, practice and the environment.

Appendix 1: Contributors

These Standards are presented as a work-in-progress on behalf of the Drugs Death Taskforce MAT Subgroup members.

Sub-group membership and additional roles:

Tracey Clusker (Clinical Lead)	**NHS Lothian Expert Group Operational Team Scottish Drug Deaths Taskforce (since October 2020)**
Michael Crook	Scottish Government Secretariat, Scottish Drug Deaths Taskforce
Elinor Dickie (Programme Lead)	**Public Health Scotland Expert Group Operational Team**
Alan Houston	Person with lived experience Scottish Drug Deaths Taskforce
Carole Hunter (since April 2020)	Chair, Scottish Pharmacists in Substance Misuse Scottish Drug Deaths Taskforce
Dr Ahmed Khan	Royal College of Psychiatrists Scottish Drug Deaths Taskforce
Dave Liddell	Scottish Drugs Forum Expert Group Operational Team
Pete Littlewood	Chair, Lead Psychologist is Addiction Services Scotland Expert Group
Jean Logan (to April 2020)	Scottish Pharmacists in Substance Misuse Scottish Drug Deaths Taskforce
Dr Carey Lunan	Royal College of GPs Scottish Drug Deaths Taskforce
Prof Catriona Matheson	Chair, Scottish Drug Death Taskforce
Dr Duncan McCormick (Chair and Lead Consultant)	**NHS Lothian Expert Group Operational Team Scottish Drug Deaths Taskforce**
Dr Alison Munro	University of Dundee
Dr Saket Priyadarshi	NHS Greater Glasgow & Clyde Expert Group
Simon Rayner	Aberdeen City ADP
Michelle Rogers	Scottish Government
Joe Schofield (Secretariat to October 2020)	Drug Research Network Scotland
Geraldine Smith	Scottish Government Operational Team
Dr Caroline Steele	Allan Park Medical Practice

Chris Wallace	Communications Consultant for Scottish Drug Death Taskforce
Becky Wood	Person with lived experience Scottish Drug Deaths Taskforce Expert Group

Contributors who are not members of the SDDT MAT Subgroup:

Dr John Budd	NHS Lothian Expert Group
Dr Fiona Cowden	NHS Tayside Expert Group
Kirsten Horsburgh	Scottish Drugs Forum Operational Team
Karen Mailer	Public Health Scotland Operational Team
Lindsey Murphy	Public Health Scotland Operational Team
Dr Trina Ritchie	NHS Greater Glasgow & Clyde Expert Group
Austin Smith	Scottish Drugs Forum Expert Group
Dr Joe Tay	NHS Lothian Expert Group
Liz Taylor	Public Health Scotland Operational Team

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